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Modern Family Planning Methods Practice among Currently Married Women in Shashamane Zuria Woreda of West Arsi in Oromia Region in Ethiopia

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Abstract

Background: Modern Family planning is a product or medical procedure that interferes with reproduction. Resource conservation and development are supported by family planning implementation. The current study had the intention of providing up to date evidence of the practice in the study setting.

Objective: To assess the utilization of modern family planning methods and associated factors among currently married women of Shashemene Zuria Woreda West Arsi Zone Oromia Ethiopia.

Methods: A community-based cross-sectional study was conducted involving 615 women. Data were collected by face-to-face interview using a pretested structured questionnaire. Then the data were entered into EPI-Info and exported to SPSS for analysis. During analysis, the odds ratio and its 95% confidence interval were used to decide statistically significant determinants at $p<0.05$.

Results: About 34.3%, 95% CI (30.9, 38.5) of the currently married women reportedly were found ever used MFP. Having awareness (AOR (95% CI):18.4 (4.7,71.5)), discussion with partners (AOR (95% CI): 6.7(4.73-7.81)), average monthly income of 1000-1500 Ethiopian birrs (AOR(95% CI):4.1(1.6,10.8)), spouse disagreement (AOR(95%CI): 0.024,(0.01,0.62)) and fear of side effects (AOR(95%CI):0.03(0.09,0.75)) were independent predictors of modern family planning utilization.

Conclusion: Utilization of modern family planning among currently married women in the study area was low. Awareness, family income, discussion with couples and spouse disagreement, and side effect concerns were determinants of MFP utilization. Awareness expansion activities, improving community livelihoods, and empowering girls and women by policymakers and implementers at the zone and higher level should be focused on. A wide scope study by including qualitative method is recommended to verify in-deep.

Keywords: Modern; Family planning; Shashamane; Married women; Ethiopia

Abbreviations: AOR: Adjusted Odds Ratio; COR: Crud Odds Ratio; CAR: Contraceptive Prevalent Rate: CI: Confidence Interval; CSA: Central Statistics Agency; EDHS: Ethiopian Demographic and Health Survey; FGAE: Family Guidance Association Ethiopia; MFP: Modern Family Planning; FP: Family Planning; HC: Health Center; HEW: Health Extension Worker; HH: Household; IUCD: Intra-Uterine Contraceptive Device; KPI: Knowledge Attitude and Practice; LAFP: Long Acting Family Planning: MCH: Maternal and Child Health; MOH: Ministry of Health; SNNP: South Nation Nationality Peoples; SPSS: Statistical Package for social science; TFR: Total Fertility Rate; UNFPA: United Nation Family Planning Association; WHO: World Health Organization

Introduction

Family planning (FP) is considered development and a life-saving intervention for millions of women and girls. Increasing use of contraceptive methods has resulted in improvements in health-related outcomes such as reduced maternal mortality and morbidity. Besides, improvements in schooling and economic outcomes, especially for girls and women empowerment were also enhanced [1]. FP began in many developing countries from the early second half of the twentieth century through the 1980s [2], whereas in Ethiopia it was established by Family Guidance

Association Ethiopia (FGAE) in1966 [3]. National Guideline for FP services in Ethiopia stated that goal of FP is to enable individuals to achieve their desired family size, ensuring sexual and reproductive health rights of women [4].

The modern family planning (MFP) method has been the most cost-effective public health measure for improving reproductive health, and gender equity among women in developing countries. Its use improves maternal health, among many others, by lowering cases of unwanted pregnancies. The level of success was influenced by the methods of implementing the program and also seems to be a function of higher socioeconomic status, educational levels, and the status of women in the country [5]. There is a consensus that FP is the key strategy towards achieving sustainable development goal programs and reduces poverty and nowadays need pool all health sector resources and allocate for its implementation [6].

More than 350 million couples worldwide had limited or no access to effective and affordable FP, especially to Long-Acting Family Planning (LAFP). A large number of women have unmet-need for FP for particular populations like those copping with conflicts and disasters [7-10]. In Sub-Saharan countries where most of the future new population assumed to born much is to be done. The utilization of MFP methods is affected by different reasons across sub-regions of Africa similar to any part of the World [11-19]. Therefore this study intended to provide evidence for the current study setting for better performance.

Methods

Study setting

A community-based cross-sectional study design was employed from 1st August to 15th September 2019 in Shashamane Zuria Woreda in the Oromia Region of Ethiopia. It is located at a distance of 250 km to the South of Capital City Addis Ababa. The woreda is geographically bounded by Shala Woreda, Bishanguracha town, and SNNPR state in the South direction, Nagele Arsi Woreda in the West, and Kofale Woreda in the East direction. Shashamne Zuria Woreda is one of the 15 Woreda of the West Arsi zone. It is a highly populated woreda than other Woredas in the zone. The total population estimation projected in 2019 to be 297,625 and 100% residing in the rural area. Women of childbearing age were estimated to be 65,775 [20]**.** The Woreda has 37 rural Kebles and no urban. The health facilities include seven functional government HCs, thirteen private clinics, and two drug vendors.

Population

The source population for this study was all households that have at least one currently married woman of childbearing age living in selected kebeles in Shashemene Zuria Woreda, whereas the study population was randomly selected households in selected kebeles in Shashemene Zuria Woreda. Childbearing-age currently married women who lived in selected kebeles for more than six months were included in the study. A woman who was sick and unable to communicate or mentally ill were excluded from the study.

Sample size determination

The sample size was determined by using a single population proportion formula. A proportion of 41.5% of currently married women utilized modern FP was taken from a previous study in Ethiopia [7]. Assumptions were 5% marginal error, 95% confidence interval for odds ratio, 1.5 design effect, and 10% non-response rate. The total sample size was 615 women.

Sampling techniques and procedures

Involving a fourth of the Kebeles in the woreda was determined. The study employed a multi-stage sampling technique that was used to select 9 Kebeles from 37 total Kebeles of the woreda by a lottery method. A sampling-frame used the number of households in the Keble Health Extension Workers' (HEW) registration books. The proportion of the total study sample size to the total household in the selected kebeles (k) was used to get the number of women to be picked up from each selected kebele. Then the kebeles were divided into gots (sub-kebeles) and the number that was assigned to the kebele was divided among those gots proportionally. Then each study unit (household) in the got was selected by using random direction methods anti-clockwise from the health post to the households that have childbearing age currently in marriage. Then K was used to locate the next household from the first and so on until the required number was achieved for each got. If more than an eligible woman in each household was found, only one was interviewed by selecting using the simple random sampling (SRS) method. A household was labeled as an absentee if unfound during three visits done by data collectors.

Variables of the study

The dependent variable for this study was MFP utilization whereas independent variables were categorized under three domains. First, socio-demographic determinants; age, religion, ethnic group, marital status, educational status, occupation, husband occupation, obstetric and Second, reproductive factors; parity, number of live children, FP ever use, MFP current use, MFP ever use, Type of ever/current use of FP, Third, psychosocial factors; Awareness of modern family planning methods, Source of information, Exposed to media, Type of media.

Operational definitions

FP means a modern method of contraceptives. MFP: a contraceptive method that includes pills, injectables, implants, IUCDs, and sterilization. MFP utilization is an ever used modern FP method in the last 5 years based on their awareness to prevent unplanned pregnancy.

Data Collection tools and procedures

Data were collected using structured questionnaires. The questionnaire adopted from DHS2016 reports [18,21,22]. After preparation in English, it was translated to a local language Affan

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Oromo. Then, it was grouped under two domains that included socio-demographic factors and reproductive factors.

Eight female nurse students for data collection and two nurses for supervision were recruited and trained by the principal investigator on study purpose and data collection techniques. Data collection tools pretest was done on 5% similar sample from neighbor kebele who were not included in the main study. Data collection was done by an interviewer-administered face-to-face method. Daily supervision, a checkup of filled data, and spot correction were made. Daily evening reviewing the process and feedback was done. Data were anonymously coded on daily basis.

Data processing and analysis

Data were entered into EPI-Info version 7 and exported to SPSS (Statistical Package for social science) version 21 for analysis. Using the frequencies and summary statistics (mean, standard deviation, and percentage) were used to describe the study population concerning relevant variables. Bivariate and multiple regression analysis models performed using SPSS. After bivariate processing, variables whose p-value were below 0.25 were considered candidates for the final multiple regression. Lastly, the odds ratio with its 95% CI at p-value < 0.05 was used as the cut of point to determine the statistical significance of the relation.

Ethical Considerations

Ethical clearance was obtained from Arsi University College of Health Sciences, Department of Public health, and a cooperation letter was obtained from East Shewa Zonal Health Office and Shashemene Zuria Woreda too. All the study participants were informed about the purpose of the study and their written informed voluntary consent to participate was obtained before administration of the interview. The participants were told privacy, confidentiality, and anonymity ensured throughout and after the study.

Results

Socio-demographic characteristics of respondents of Shashamane Zuria Woreda

The study was held on married women age 15-49 years old. Age distribution was 15-19 years 39(6.3) age 20-24 years 184(29.9%) and 25-49 years 392(63.7%). The majority of the respondents (521(84.3%)) were Oromo by their ethnic group and, (491(79.4%)) were Muslim followers while 520 (84.1%) were living with their husbands (Table 1).

Table 1: Socio-demographic and socio-economic characteristic of respondents in Shashamane Zuria Woreda, Oromia, Ethiopia, 2020.

Variables	Frequency	Percent
Age in years (n=615)		
17-19	39	6.34
20-24	184	29.91
25-49	392	63.74
Ethnic group (n=615)		
Oromo	521	84.3
Amara	18	2.9
SNN	76	12.4
Religion (n=615)		
Orthodox	21	3.41
Muslim	491	79.84
Protestant	103	16.75
Mothers' educational status (n=615)		
Cannot write and read	334	69
Can write and read	166	26.9
Grade 1st-8th	92	14.9
Grade 9th and above	23	3.7
Husbands' educational status (n=615)		
Cannot write and read	240	38.8
Can write and read	218	35.3
Grade 1st-8th	106	17.2
Grade 9th and above	51	8.3

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Mothers' occupation (n=615)		
Housewives	541	88
Government employees	10	1.6
Merchants	49	80
Daily laborers	15	2.4
Husbands' occupation(n=615)		
Farmers	469	75.9
Government employees	30	4.9
Merchants	52	8.4
Daily laborers	64	10.4
Family's' monthly income ETB(=615)		
<1000	369	60
1001-1500	103	16.75
1501-2000	54	8.78
>2001	89	14.47
Number of living children (n=615)		
Not have a child	102	16.59
One to two children	252	40.98
Three to four children	156	25.37
More than children	105	17.07
Number of the husbands' wives (n=615)		
One	410	66.67
Two	174	28.29
Three or more	31	5.04

Utilization and awareness of MFP of respondents in Shashamene Zuria Woreda

MFP utilization was 211(34.3%) with 95% CI (30.9, 38.5). Greater than 90% of respondents had awareness of MFP 557(90.6%). Source of information about MFP was health worker for 420(65.3%), friends/peer for 40(6.8%), health facility for 91(14.8%), and other sources like media in 16(2.8%) (Table 2).

1. Complete education, not to miss work…
2. Radio, TV
3. Emergency, condom,
4. Condom, Em
5. Discrimination by others

Factors Associated with the utilization of MFP in Shashemene Zuria Woreda.

Married women who have awareness of MFP were more than 18 times more likely to utilize MFP than their counterparts ((AOR (95% CI); 18.39(4.73, 71.52)). Married women whose spouses do not agree to use MFP were less likely than their counterparts. Married women who discussed MFP use were more than three times more likely to MFP than those who have not discussed MFP use ((AOR(95% CI); 3.72 (1.94, 18.97)) (Table 3).

Discussion

MFP utilization of this study was 34.3% with 95% CI (30.9,38.5) among those who were married, in Shashamane Zuria Woreda; the finding greater than this study is in Bale Zone of Oromia Regional State of, Southeast Ethiopia: 41.5% [7] Arab Minch, SNNPR, Ethiopia 63.9% [8]. southwestern, Saudi Arabia (58.8) [9] and Dang District, Nepal 47% [10], and DHS2016 of Malawi (58%) [21]. But it is similar to DHS2016 reports of Ethiopia (35%) [18] and Uganda (35%) [22] and also some discrete studies from Northwest Ethiopia reported nearly similar findings Fenote Selam (37%) and Rural Dambia Woreda (31.7%) [11,12]. There are also some studies with far fewer reports like Afar and Tigray regions (8.5% and 12.3%) [13,14] respectively. The differences might be due to the differences in settings, technique, and study time while the DHS is more representative referring to its scope.

About 45.5 % of the respondents presented belief as a pretext for not practicing MFP that was far more than the reports in Bale (17.7%) but far less than the report in Afar (85%) in Ethiopia [7,13]. The reason for not using MFP by 12% of women in the study was spouse disagreement. This reason is important even

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if the proportion seems less since the joint decision is more guaranteed for better and sustainable practice. This is accounted for 38.8% in Bale [7] as the report shows while the fear of side effects nearly was similar to the current report (5.4% and 5.9% respectively). The majority of mothers who used MFP 156(25.4%) reportedly used injectable form followed by implant 36(5.9). The was similar to reports from previous studies in Ethiopia that reports among the method mix the injection is the most common modern contraceptive method used by married women [15-18]. Women who have awareness of MFP were more likely to use it than those who have no (AOR-18.4, 95% CI (4.73, 71.52) Family with low monthly income were four times more likely to use the MFP method than a family who has larger average monthly income ((AOR, 95% CI); 4.08(1.55,10.76)). This is an inconsistent finding to the report UNFPA state of world population 2017 book [4]. This can be due to the dissimilarity inherent to the scope and methods of the studies.

Table 2: Utilization and awareness of MFP of respondent Shashamane Zuria Woreda, Oromia, Ethiopia, 2019.

Variables	Frequency	Percent
Awareness of FP(n=615)		
No	48	7.8
Yes	567	92.2
Purpose of FP(n=567)		
Prevention of pregnancy	178	28.9
Birth spacing	243	39.5
Birth control	67	10.9
Pregnancy limit	19	5
Planning family	48	8.5
Others[1]	17	2.8
Awareness of MFP (615)		
No	58	9.4
Yes	557	90.6
Ever use of MFP(n=615)		
No	404	65.7
Yes	211	34.3
Currently, the use of MFP (557)		
No	456	74.1
Yes	159	25.9
Heard information from (557)		
Extension Health worker	420	68.3
Friend	40	6.5
Health facility	91	14.8
Others[2]	16	2.6
Type of ever use of MFP methods		
Pills	17	2.8
IUCDs	12	2
Injection	156	25.4
Implant	36	5.9
Others[3]	17	2.8
Types of the current use of MFP methods (159)		
Pills	12	2
IUCDs	12	2
Injection	69	11.2
Implant	74	12

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Others[4]	12	2
Reason for not using FP		
Against to my Belief	279	45.4
Spouse disagree	74	12
Don't Know the reason	35	5.7
Fear of side effect	33	5.4
Others[5]	40	6.5
Discuss MFP		
No	330	53.66
Yes	285	46.34
Who decides for using FP		
Self	81	13.2
Husband	189	30.7
Jointly	105	17.1
I don't	29	4.7

Table 3: Factors associated with the utilization of MFP methods in Shashamane Zuria Woreda, Oromia, Ethiopia, 2020.

Variables	Used MFP		COR (95% CI)		AOR (95% CI)	
	No (%)	Yes (%)				
Have awareness of MFP						
Yes	346(85.6)	205(97.2)			18.4	(4.73, 71.52)*
No	58(14.4)	6(2.8)	1		1	
Family Monthly income (in birr)						
<1000	260(32.9)	109(21.8)	0.35	(0.25,0.48)	1.45	(0.60,3.48)
1001–1500	44(10.9)	59(28)	1.34	(0.91,1.98)	4.09	(1.55,10.76)*
1501–2000	34(8.4)	20(9.5)	0.59	(0.34,1.02)	0.85	(0.25,2.87)
4.>2000	66(16.3)	23(10.9)	1		1	
Number of their husbands' wives						
One	280(69.1)	130(61.6)	975	(0.45,2.13)	1.5	(0.40,5.57)
Two	103(25.7)	71(33.6)	0.46	(0.64,3.26)	2.79	(0.72,10.78)
≥ Three	21(5.2)	10(4.7)	1		1	
Reason for not using MFP						
Against my Religion	250(61.9)	29(13.7)	1		1	
Spouse not agree to use	60(14.9)	14(6.6)	0.01	(0.01,0.02)	0.02	(0.01,0.06)*
Don't have awareness of FP	30(7.4)	5(2.4)	0.03	(0.01,0.08)	0.11	(0.03,0.45)*
Fear of side effects	24(5.9)	94.3)	0.14	(0.03,0.64)	0.03	(0.01,0.06)*
Discussed MFP use						
No	246(60.9)	84(39.8)	1			1
Yes	158(39.1)	127(60.2)	0.8	(0.64,1.02)	3.72	(1.28,10.85)*
Decides on use MFP						
Self	37(9.2)	44(20.9)	1			1
Husband	153(37.9)	36(17.1)	3.64	(2.12,6.23)	2.06	(0.86,4.90)
Jointly	31(7.7)	74(35.1)	0.72	(0.45,1.16)	1.22	(0.34,4.43)
Don't know	24(5.9)	5(2.4)	7.3	0(.23,1.75)	0.32	(0.07,1.45)

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From the current study more than half of the participants accessed information from Extension Health Workers 420(68.3%) followed by health professionals 91(14.8%) and other sources like media 56 (9.1%) [19]. When we see the awareness of modern family planning methods, it showed more than 80% of currently married women have awareness. A similar study in Ethiopia reported that about 90% of currently married women have awareness of MFP [16] and another study from Dang district in Nepal community-based cross-sectional study [10].

Women who make a discussion on MFP were more likely to utilize compared to their counterparts (AOR=3.72, 95% CI (1.25, 10.85). This is consistent with a similar study in the West district of Ghana [15]. This is due probably to the empowering effect of discussing the issue of FP. The effect of religion was compared against the effect of spouse disagreement, fear of side effects, and lack of awareness. The negative effect of these factors exceeded that of perceived effect of their religion [spouse disagreement (AOR=0.02, 95% CI (0.01, 0.06), lack of awareness (AOR=0.11(0.03, 0.45) and fear of side effect (AOR=0.03, 95% CI (0.01, 0.06)]. No such a comparison to the knowledge of the authors so far. But this was a very interesting finding because all the participants were living in rural settings, nearly 80% have never been to school, and almost 80% were Muslim in some settings sees conservatives. So in the current study setting focusing on awareness creation, explanation of safety, and male participation can improve MFP use.

This study has a strength that it's a high response rate of 100% and acquired information directly from members of the community to make the finding more representative. The users of this research results must bear in mind that it also is not free of limitations. Since this study was limited to married women only at the time of the study; results may not be generalized to all women that were not married in the study area. The study was cross-sectional and a question of cause and effect is unanswered, the study is of small sample size and place to be inferred widely.

Conclusions and Recommendations

Finding from this study showed utilization of MFP among married women in Shashemene Zuria Woreda was low when compared to EDHIS 2016. Monthly family income estimate, awareness, reason not to use MFP, discussion on MFP use, and decision on MFP use were the key factors of the utilization of MFP methods in the setting. Finally, authors recommend an in-depth, detailed qualitative study on factors associated with MFP utilization, because still, it needs a study that covers a wide area and stakeholder including the whole community.

Declarations

Ethical and study protocol approval

The Ethical Review Committee of the College of Health Sciences of Arsi University approved the study protocol and Ethical procedure. A written informed voluntary consent to participate was obtained from each participating woman after explaining to them all the purpose of the study. The right of the participants to withdraw from the interview at any step during the interview was assured. Any personal identifiers have been differed during the study and were replaced by identification numbers.

Consent for publication

Not applicable.

Availability of data and materials:

Our data will not be shared to protect the participant's anonymity but secured in the investigators' database as per the Arsi University research regulations.

Competing interests

Authors declare there is neither financial nor non-financial conflict of interest.

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Contribution of the authors

TGB developed the conception, design, data acquisition, analysis, and result writing. LTW and DMT supported the study conception, designing, and data management and critically reviewed the report and prepared the manuscript to the current level. Finally, all the authors read and approved the manuscript for publication.

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